Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

HB 1215

Brief Description: Prohibiting balance billing by health care providers.

Sponsors: Representatives Schmick and Sells.

Brief Summary of Bill

- An out-of-network provider that provides services at an in-network facility may not balance bill an enrollee for emergency services provided to an enrollee at an in-network hospital, or nonemergency health care services provided to an enrollee person at an in-network hospital or ambulatory surgical facility if the services involve surgical or ancillary services.

Hearing Date: 1/23/19

Staff: Kim Weidenaar (786-7120).

Background:

Balance Billing.
When an enrollee receives covered health services from an in-network health care provider, he or she is held harmless for the difference between what the health carrier pays the provider and what the provider normally charges for the services. If the person receives services from an out-of-network provider, however, the provider may bill the person for this difference. This practice is known as "balance billing."

Emergency Services under Federal Law.
Under the Emergency Medical Treatment and Active Labor Act, a hospital must screen, evaluate, and provide treatment necessary to stabilize any patient who comes to the emergency department with an emergency medical condition. Under the Affordable Care Act (ACA), a health carrier that offers coverage for services in an emergency department must cover emergency services without prior authorization, without regard to whether the provider is in-network or out-of-network, and with no differential copayments or coinsurance for out-of-network services.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

"Emergency services" and "emergency medical condition" are defined the same as in state law. The rules implementing the ACA provide a payment methodology for emergency services provided by out-of-network providers. An out-of-network provider may "balance bill" the patient for the balance between the provider's billed charges and the amount the provider was paid by the carrier.

Emergency Services under State Law.
Under state law, a health carrier must cover "emergency services" provided at an out-of-network emergency department if the services were necessary to screen and stabilize an enrollee and a prudent layperson would reasonably have believed that use of an in-network hospital would result in a delay that would worsen the emergency or if use of a specific hospital is required by federal, state, or local law. Likewise, a health carrier may not require prior authorization of emergency services in an out-of-network emergency department if the prudent layperson standard is met. If the carrier authorizes coverage for emergency services, the carrier may not retract the authorization or reduce payment after the services have been provided unless the approval was based on the provider's material misrepresentation about the enrollee's health condition. Coverage of emergency services may be subject to applicable copayments, coinsurance, and deductibles. Except under certain circumstances, a carrier may impose reasonable differential cost-sharing arrangements for in-network and out-of-network emergency services.

"Emergency services" are defined as a medical screening examination within the capability of a hospital emergency department, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition, and further medical examination and treatment to the extent they are within the capabilities of the staff and facilities at the hospital, as required to stabilize the patient.

"Emergency medical condition" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in a condition placing the person's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of a bodily organ or part.

Summary of Bill:

Prohibition on Balance Billing.
An out-of-network provider that provides services at an in-network facility may not balance bill an enrollee for:

- emergency services provided to an enrollee at an in-network hospital; and
- nonemergency health care services provided to an enrollee at an in-network hospital or ambulatory surgical facility if the services involve surgical or ancillary services.

"Balance bill" is defined as a bill sent to an enrollee by an out-of-network provider for health care services provided to the person after the provider or facility's billed amount is not fully reimbursed by the carrier, exclusive of permitted cost-sharing. "Surgical or ancillary" services are defined as surgery, anesthesiology, pathology, radiology, laboratory, or hospitalist services.

The balance billing provisions apply to health carriers regulated under the insurance laws and health plans offered to public employees and their dependents, but do not apply to Medicaid. The provisions must be liberally construed to ensure that consumers are not billed out-of-network charges.

The Insurance Commissioner may adopt rules to implement and administer the act.

Payments by the Enrollee.

If an enrollee receives health care services for which balance billing is prohibited:

- The enrollee satisfies his or her obligation to pay for the services if he or she pays the in-network cost-sharing amount specified in the enrollee's or applicable group's health plan contract.
- A carrier, out-of-network provider, or out-of-network facility, or agent, trustee, or assignee:
    - must ensure the enrollee incurs no greater cost than the enrollee would have incurred if the service had been provided by an in-network provider at an in-network facility;
    - may not balance bill or otherwise attempt to collect from the enrollee more than the in-network cost-sharing amount, but may continue to collect a past-due balance for the cost-sharing amount plus interest;
    - may not report adverse information to a credit reporting agency or bring suit against an enrollee until 150 days after the initial billing; and
    - may not use wage garnishments or liens on a primary residence to collect unpaid bills.
- The carrier must treat any prior cost-sharing amounts paid in the same manner as cost-sharing for in-network services and must apply paid cost-sharing amounts toward the limit on enrollee's in-network out-of-pocket maximum expenses.
- If the enrollee pays an amount in excess of the in-network cost-sharing amount, the provider, facility, or carrier must refund the excess within 30 business days. After 30 business days, interest is owed on the unrefunded payment at a rate of 12 percent.

Appropriation: None.

Fiscal Note: Not requested.

Effective Date: The bill contains an emergency clause and takes effect on January 1, 2020.